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Supporting Safe Motherhood

A Review of Financial Trends

Summary

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Almost 500,000 women a year from developing countries die from pregnancy-related causes. In 1987, an international conference in Nairobi, Kenya launched a global Safe Motherhood Initiative with World Bank co-sponsorship. By 1989, how were the donors responding to the Initiative?

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This paper — a product of the Population, Health, and Nutrition Division, Population and Human Resources Department — is part of a larger effort in PRE to promote policy and resource commitment to the Safe Motherhood Initiative. Copies are available free from the World Bank, 1818 H Street NW, Washington DC 20433. Please contact Sonia Ainsworth, room S6-065, extension 31091 (16 pages with figures).

Financial trends for safe motherhood initiatives. Problems of definition and accounting methods preclude an accurate analysis of financial trends among donors. Global support for specific safe motherhood activities is limited. For the 17 major bilateral sources, funding for selected activities which contribute to safe motherhood is estimated to have increased (in current dollars) from $691.5 million in 1986 to $818.8 million in 1988. About half this amount was for so-called core* activities, including family planning services. The magnitude of support for prevention of the complications of pregnancy is less certain. General health, population, and nutrition sector flows increased substantially over the same period. These trends were positive for 13 sources, unchanged for three, and negative for one.

Of the six major multilateral sources, totals for selected safe motherhood activities were estimated to be $477.7 million in 1988, a 41.7 percent increase over 1987 and a 17 percent increase over 1986, reflecting differences in the annual volume of World Bank loan approvals. Half of this went for core services, primarily family planning.

Estimated World Bank safe motherhood expenditures in 1989 are triple the previous year's total. This is due primarily to substantial increases in general loans for health, population, and nutrition. New specific safe motherhood activities are beginning to emerge in the form of care for the complications of pregnancy, better secondary and tertiary facilities, training, and promotional workshops.

The magnitude and effectiveness of donor financing will require more attention to two special problems:

- Strengthening recipient countries' ability to articulate project demand — providing specific training, technical advisory assistance, and operational guidelines for mobilizing financial resources.

- Improving the data on safe motherhood financial trends — establishing a consensus on definitions; seeking a consensus on financially measurable program or project categories of safe motherhood; defining methods for the systematic collection of donor and recipient country data on financial trends.

For the full section on Interview Notes with different financing sources, see WPS 413.

* At the 1987 Conference on Safe Motherhood in Nairobi, Herz and Measham recommended a core program for safe motherhood that included reducing the number of pregnancies through family planning education, promotion, and community-based services; reducing the risks to pregnancy and childbirth; providing prenatal care, supervised deliveries, screening, and referral for high-risk mothers; and providing communication and transportation for complicated deliveries.

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The author is an M.D., Dr. P.H consultant to the World Bank, and Senior Adviser, The Pragma Corporation. He wishes to express appreciation and thanks for the generous time and cordial cooperation extended by those interviewed. The informality of these meetings and the ability to exchange views were of immense value in gaining a perspective on the outlook for the Safe Motherhood Initiative. The author regrets that an internal reorganization of NORAD precluded a visit to Oslo. All conversations are considered unofficial exchanges and the author accepts full responsibility for estimates and interpretation.

The World Bank initiated this study with the endorsement of the Safe Motherhood cosponsors. Special thanks all extended to Bank staff for guidance and support, in particular to Dr. Anthony Measham, Chief of Population, Health, Nutrition Division; Dr. Barbara Herz, Chief of the Women in Development Division; Dr. Frederick Sai, Senior Population Adviser; Mrs. Eleanor Folta (PHN Division) and Ms. Anne Grimsrud (Women in Development Division).

The Director General of WHO, Dr. Hiroshi Nakajima, and his Director for Planning, Coordination and Cooperation, Dr. Yuji Kawaguchi, shared their perspectives on the problems and outlook for financial resource mobilization. Dr. Mark Belsey, chief of the Maternal and Child Health Unit at WHO, Geneva, was most helpful in collaborating on the initial design of the study, and his cooperation in arranging for a field questionnaire is greatly appreciated.

TABLE OF CONTENTS

I. INTRODUCTION

At the February 1987 Conference on Safe Motherhood in Nairobi[1], Herz and Measham (1987) presented a paper on "The Safe Motherhood Initiative," in which they proposed a new approach to reduce maternal mortality and morbidity in developing countries. Herz and Measham noted that in spite of progress toward child survival and improvements in life expectancy, an estimated 500,000 women, 99 percent of them from the developing world, die each year from pregnancy-related causes[2].

About three quarters of these deaths are the direct result of obstetrical complications -- hemorrhage, infection, toxemia, obstructed labor, and abortion (under primitive and illegal conditions). An estimated equivalent number of infants do not survive their mother's death. For surviving mothers, the consequences of pregnancy have a severe impact on health and family economics.

The proposed strategy for safe motherhood is based on two approaches. First, the encouragement of activities that indirectly improve maternal health. These include education, policies to improve women's rights and working conditions, health care and nutrition, transportation and communication systems, water and sanitation facilities, and increases in family income and food production.

The second approach, which serves as the core strategy for the Safe Motherhood (SM) Initiative targets activities to reduce maternal deaths. These activities include reducing unwanted pregnancies through the provision of family planning services, and through national policies that recognize the importance of this issue (although Maine (1985) estimates that even if all unwanted pregnancies were avoided, only a fourth to two fifths of maternal mortality would be avoided).

A second objective is to reduce the risks of pregnancy through providing community-based family planning and prenatal services to identify high-risk cases' adequate referral services for the complications of pregnancy, and communication and transport systems to support patient referral procedures.

Given the long history of support for maternal health by international bilateral, multilateral, and nongovernmental organizations (NGOs), the conference recognized that the limited progress in reducing maternal mortality and morbidity required moving to a systems approach utilizing selected, targeted, core activities.

II. TERMS OF REFERENCE

A. *Purpose*

In response to a request from the Meeting of Interested Parties, which serves as the international forum for monitoring the Safe Motherhood Initiative, the World Bank has undertaken this study to measure aid flows for this program since the 1987 conference. The study is designed to measure financial trends and new initiatives in support of the program's objectives; identify issues of statistical methodology that may constrain the analysis, and establish a baseline for 1988 against which to measure future financial trends.

A second objective of the study is to identify SM policies and programs among the major official sources of external financing. In view of the four-month timetable to complete this study, it concentrates on Official Development Assistance (ODA) and does not include nongovernmental and private contributions except for official contributions to nongovernmental organizations (NGOs)[3].

The expectations of this review are modest in view of four factors:

1. The wide variations in statistical methods for recording maternal health data make it difficult to compare data sets.

2. New projects started immediately after the conference are unlikely to have recorded expenditures in time to be included in this review.

3. The absence of international uniformity on the criteria for the initiative and the wide range of activities with direct and indirect maternal health effects means that much of the data were based on interpretations.

4. The relatively brief duration of the study.

B. *Assumptions*

1. The study looks at financial flows rather than cost-effectiveness, and does not assume that magnitude of investment is directly correlated to improvements in maternal health.

2. Because there is no comprehensive global system to monitor health expenditures by developing countries or external sources, the data would have to be obtained from each financial source.

3. Because of variations in statistical recording systems and in definitions of health, full comparability would be difficult to assure.

4. It would be premature to expect identifiable new financing specifically addressing the initiative. Official statistical systems have not been adjusted to identify SM components. As a result, the data reflect unofficial estimates derived from multiple sources. The author, not the sources, is responsible for the composite estimate.

5. To accomplish the study in the four-month period prior to the June 1989 Meeting of Interested Parties, direct interviews with the major bilateral and multilateral financial sources were considered preferable to risking a low response rate to a mailed questionnaire. For developing countries, however, the sources of information were resident WHO and UNDP representatives.

C. *Methodology*

1. The study drew on data sets for 1985 to 1989 in order to permit a comparison of trends before and after the Nairobi conference.

2. The data were examined for characteristics that would identify components.

3. Where there were no specific components within a health loan or primary health care program, the respondent was asked to estimate the amount of financing for SM. Information from interviews was supplemented by the official annual reports of bilateral and multilateral agencies.

4. For purposes of comparison, each financial source was asked to use common definitions and to include all major categories of ODA for the health sector as follows: